

Prescriber Criteria Form

Trastuzumab BDC 2026 PA Fax 1499-A v1 010126.docx
 Herceptin (trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb),
 Ontruzant (trastuzumab-dttb), Hercessi (trastuzumab-strf)
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
 Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact
 CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are
 met, we will authorize the coverage of Trastuzumab.

Drug Name (select from list of drugs shown):

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION

1	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished "incident to a practitioner's service")? [If yes, then no further questions.]	Yes	No
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CRITERIA FOR APPROVAL

2	Does the patient have a diagnosis of breast cancer? [If no, then skip to question 8.]	Yes	No
3	Is the disease human epidermal growth factor receptor 2 (HER2) positive? [If no, then no further questions.]	Yes	No
4	Is the requested drug being used for the treatment of leptomeningeal metastases from breast cancer? [If yes, then skip to question 24.]	Yes	No
5	Is the requested drug being used for the treatment of brain metastases from breast cancer? [If yes, then skip to question 24.]	Yes	No

6	Is the requested drug being used as neoadjuvant therapy? [If yes, then skip to question 24.]	Yes	No
7	Is the requested drug being used in one of the following clinical settings: A) treatment of recurrent, advanced unresectable, or metastatic disease, B) adjuvant therapy? [If yes, then skip to question 24.] [If no, then no further questions.]	Yes	No
8	Does the patient have a diagnosis of HER2 overexpressing gastric or gastroesophageal junction cancer? [If no, then skip to question 10.]	Yes	No
9	Is the disease locally advanced, metastatic, unresectable, or recurrent? [If yes, then skip to question 24.] [If no, no further questions.]	Yes	No
10	Does the patient have a diagnosis of HER2-positive esophageal or esophagogastric junction adenocarcinoma? [If yes, then skip to question 24.]	Yes	No
11	Does the patient have a diagnosis of HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma? [If yes, then skip to question 24.]	Yes	No
12	Is the requested drug being used for the treatment of a HER2-positive recurrent salivary gland tumor? [If yes, then skip to question 24.]	Yes	No
13	Does the patient have a diagnosis of RAS and BRAF wild type colorectal cancer, including appendiceal adenocarcinoma? [If no, then skip to question 18.]	Yes	No
14	Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? [If no, then no further questions.]	Yes	No
15	Has the patient been previously treated with a human epidermal growth factor receptor 2 (HER2) inhibitor? [If no, then skip to question 17.]	Yes	No
16	Does the patient have metachronous metastases? [If no, then no further questions.]	Yes	No
17	Will the requested drug be used in combination with pertuzumab, tucatinib, or lapatinib? [If yes, then skip to question 24.] [If no, then no further questions.]	Yes	No
18	Does the patient have a diagnosis of hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)? [If no, then skip to question 22.]	Yes	No

19	Is the disease unresectable or metastatic? [If no, then no further questions.]	Yes	No
20	Does the patient have human epidermal growth factor receptor 2 (HER2)-positive disease? [If no, then no further questions.]	Yes	No
21	Will the requested drug be used in combination with pertuzumab or tucatinib? [If yes, then skip to question 24.] [If no, then no further questions.]	Yes	No
22	Does the patient have a diagnosis of human growth factor receptor 2 (HER2)-positive endometrial cancer? [If no, then no further questions.]	Yes	No
23	Will the requested drug be used in combination with paclitaxel and continued as a single agent for maintenance therapy? [If no, then no further questions.]	Yes	No
24	Does the patient meet both of the following: A) the patient had an intolerable adverse event to Trazimera, B) that adverse event was NOT attributed to the active ingredient as described in the prescribing information?	Yes	No

Comments:	
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____